



**OFFICE OF THE VICE PRESIDENT FOR STUDENT
AFFAIRS AND ENROLLMENT MANAGEMENT**
JACKSONVILLE STATE UNIVERSITY

Licensed Provider Recommendation for Hardship Withdrawal

Provider: _____ Phone: _____

Address: _____ City: _____ State: _____

Provider Credentials. **Mark all that apply:** ☐ MD ☐ DO ☐ DNP

☐ **Mental Health Professional** Please specify: _____

NPI #: _____ License Number: _____ State of Issue: _____

Patient's Full Name: _____

Patient's Date of Birth: _____

Patient's Diagnoses with ICD-10 and/or DSM Codes: _____

How has the condition interfered with the patient's academic performance, safety, or wellbeing at Jacksonville State University during the term for which the patient requested a medical withdrawal?

Please provide any additional information relevant to your recommendation for medical withdrawal for the patient on office letterhead and attach.

With my signature below, I provide my recommendation for medical withdrawal from the _____ term or semester, 20____ at Jacksonville State University. The patient has given me permission to share the foregoing information with Jacksonville State University officials.

Signature: _____ Date: _____

Stamp: _____

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